ENCOUNTER KEYS

Arizona Health Care Cost Containment System

January-February 2007

OPFS Updates

OPFS Peer Groups

The AHCCCS Facility Out Patient Fee Schedule (OPFS) Peer Group Modifiers document was updated January 19, 2007 to reflect an ID. change for Havasu Regional Medical Center. Please let us know if you have any questions.

For OPFS reimbursement purposes, Carondelet Holy Cross has Small Rural designation 7/1/2005 thru 7/31/2006 and has Critical Access Hospital designation effective 8/1/2006 and forward.

Please note that this retro-active designation will require Carondelet Holy Cross to resubmit any Outpatient claims paid under the OPFS methodology for dates of service on or after 8/1/2006 to ensure that the appropriate Peer Group Modifier (PGM) percentage is applied. Information pertaining to the OPFS Modifiers can be found at the AHCCCS website:http://azahcccs.gov/RatesCodes/

Reminder on Out Patient Fee Schedule (OPFS)

The OPFS Methodology does uses modifier '51 where appropriate for Multiple Surgery processing. The AHCCCS internal OPFS processes for claims and encounters does not require the submission of the '51 multiple surgery modifier, as logic is in place to interrogate the claim and place the '51 modifier on the pricing record for the line or lines for which it is applicable.

Whether or not a health plan/program contractor requires the '51 modifier to be reported is more of a "how" issue under the methodology and we tried not to dictate each health plans/program contractors billing rules for their providers in areas such as this (just that all Health Plans/Program Contractors needed to accommodate multiple surgery valuation). Also, from our individual discussions with each plan, we understood that there are some limitations within systems that would not allow us to dictate that the health plans process these claims.

Inside this issue:

Technically the '51 modifier is used for processing of the valuation of the claims and would not normally need to be reported by the hospital, in other words its how we (and the plans) discount the amounts to be paid appropriately. If a plan chooses to require Hospitals to submit using the '51 modifier this must be clearly outlined in your billing rules. However, as long as a plan keeps clear audit trail that shows when internal systems append the 51 modifier to the claim to support processing, you aren't really "changing" the claim record just adding processing parameters to it (much like they would indicate non-covered charges, etc. ..), and that is acceptable also. Please contact the AHCCCS Outpatient Workgroup, AHCCCSOutpatientHospitalFeeSchedule@azahcccs.gov if you have questions, regarding this methodology.

Out Patient Fee Schedule (OPFS) rates

Just a reminder new Out Patient Fee Schedule (OPFS) rates effective for Outpatient dates of services on or after 10/1/2006 should now be in use as appropriate for Health Plan/Program Contractor claims paid under the OPFS methodology. If you have any questions please let us know.

Error Codes

Many plans were not able to change all of their provider contracts when OPFS methodology was implemented July 1, 2005. Therefore, Health Plan provider implementation dates varied across several months. Due to these varied implementation dates, plans have pended encounters for OPFS methodology errors. To clear out these pend errors and allow for multiple phase-in periods AHCCCS has elected to set the edits below to soft until January 1, 2006. **Effective January 1, 2006 dates of service the edits will be hard.**

- V036 HCPC Required for Revenue Code
- V037 HCPC Not Appropriate for This Revenue Code
- V407 Procedures Cannot be Concurrently Billed
- V535 Procedure Modifier Invalid for Procedure Code

"Nothing can be loved or hated unless it is first known."

Leonardo Da Vinci

NPI: Get It. Share It. Use It.

CMS Commonly Asked NPI Questions

CMS has compiled a list of resources that will help to answer many questions on NPI. Visit http://www.cms.hhs.gov/NationalProvIdentStand/07_Questions.asp#TopOfPage to view this resource. Additionally, CMS continues to build its database of Frequently Asked Questions (FAQs) on NPI. Recently, an FAQ on Electronic File Transfer (EFT) of payments from health plans to health care providers was added. You can view all existing NPI FAQs at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lvl1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl on the CMS website.

AHCCCS Commonly Asked NPI Questions

Q - It's my understanding that AHCCCS is going to stop issuing the new AHCCCS provider id# to providers when NPI becomes effective in May 23, 2007, is this correct?
A - While, It is true that we will stop "issuing provider ID's to healthcare professionals", AHCCCS will continue to assign an AHCCCS provider registration ID.

Q - When AHCCCS stops issuing the new AHCCCS Provider ID#s to providers, would AHCCCS still create or assign new 6 digits AHCCCS provider id# internally to map its own number to the NPI? Is AHCCCS always going to use its own 6 digits provider id# to map or link back to the NPI#?
A - AHCCCS will continue to create a 6 digit AHCCCS ID for internal processing purposes. For the duration of time AHCCCS continues to use the existing PMMIS system, it will crosswalk between the two ID numbers.

Q - Starting May 23, 2007, are we still going to see 6 digits AHCCCS Provider ID# on the AHCCCS Monthly Provider file?
A - The AHCCCS provider ID number will remain on the monthly file for the foreseeable future.

Q - From PMMIS (AHCCCS on-line system), is AHCCCS going to still display its own 6 digits provider id# when the NPI becomes mandatory in May 2007? Are we going to be able to search by the 6 digits AHCCCS provider id# from PMMIS?
A - This functionality varies by screen. Some screens will have both ID's available and others will have the AHCCCS provider registration ID only. Most screens will be able to look up the other ID if it is not present. We would need to know the specific screen in question to answer the question more completely. You could also simply verify by using the application. All planned changes to PMMIS are currently in production.

Key NPI Facts

The Centers for Medicare and Medicaid Services (CMS) along with the Workgroup for Electronic Data Interchange (WEDI) and other industry health plans would like to remind providers of the following key NPI facts:

- Every covered health care provider must get and use the NPI; and even if a health care provider is an individual and is not conducting electronic transactions and is, therefore, not a covered provider, he or she may be required by health plans or employers to obtain an NPI.

- The NPI is not just a number. It does affect internal and external business and systems operations and can affect the appropriate payment of claims in a timely manner.
- It is estimated that use of the NPI can require a transition period of no less than 120 days.
- Providers should begin to test and use their NPIs in electronic health care transactions no later than January 31, 2007.
- May 23, 2007 is not when the process starts, but when the process must be completed.
- Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date.
- A health care provider who is a sole proprietor is considered an individual and can only have ONE NPI.

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes -- including designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them.

NPIs are FREE!

Health care providers should know that getting an NPI is free. You do not need to pay an outside source to obtain your NPI for you. All CMS education on the NPI is also free. CMS does not charge for its education or materials.

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203.

System Updates

Health Plan Testing in PMMIS

Health Plan test files must contain valid NPI information as appropriate. This also means that the HP users will need to log onto 'ADMH' to view any encounter submitted by them. Log onto the mainframe using CICSAUAT, key in your userid and password, then key in ADMH. If you have any questions please contact your technical assistant.

Frequency of the Provider Extract

Effective February of 2007 through July 2007, AHCCCS will produce the current bi-monthly provider Extracts on a weekly basis.

This information will then be available to allow Contractors the opportunity to review the most current NPI information contained in the AHCCCS Provider file and work with their providers to get the gaps filled on as timely a basis as possible. If you have any questions please let us know via e-mail to Lori Petre at: Lori.Petre@azahcccs.gov.

Changing Web Address

Effective November 4, 2006 the following web addresses changed. This is the result of HMS' acquisition of PCG's Benefit Solutions Practice Area. Listed below are the previous websites along with the new ones.

Website	**Old**	**New** (effective 11/4/2006)
Trauma Referrals	https://cmts.pcgus.com/accident/	https://cmts.hmsy.com/accident/
TPL Referrals	https://cmts.pcgus.com/tplreferrals/	https://cmts.hmsy.com/tplreferrals/

Provider Type (PT)

Effective with dates of service on or after October 1, 2006 the provider type 18 (Physicians Assistant) and provider type 19 (Registered Nurse Practitioner) can report the following CPT code 73050 (Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction).

Edits

Effective with dates of service on or after July 1, 2004 the edit U235 (Days Billed Exceed 999) has been set from "S" (soft) to "Y" (pend).

American Dental Association (ADA) Dental Claim Form

The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by dentists and payers.

The latest version of the dental claim form enables reporting of a National Provider Identifier (NPI), in addition to a current proprietary provider identifier, for both the Billing Dentist/Dental Entity and for the Treating Dentist. This version of the form became **valid for use on January 1, 2007**.

Three samples of the ADA Dental Claim Form are available for your review. Go to the website listed to attain the copies. http://www.ada.org/prof/resources/topics/claimform.asp

Code Changes

- Effective for dates of service on or after April 1, 2006 the changes for HCPCS code S0347 (Electrocardiographic Monitoring/Home Computerized Telemetry) are listed below for the specific reference screens:

Reference Screen (RF113 Procedure Code Indicators & Value)

	Current
Medicare Coverage	N
Confidential Services	N
Family Planning	N
Sterilization	N
Abortion	N
EPSDT	N
Minimum Age	000
Maximum Age	999

RF124 (Procedure Prior Authorization) - Coverage Code 4 (Not covered service/Code not available)

RF115 (Place of Service) 99 (Other unlisted facility)

•Effective with dates of service on or after November 20, 2006 the HCPCS code J7330 (Autologous cultured chondrocytes, implant) now has a coverage code of 04 (Not covered service/Code not available).

•Effective with dates of service on or after January 1, 2006 the HCPCS code C9726 (RXT breast app. Place/ remove) now has a coverage code of 04 (Not covered service/Code not available).

•Effective for dates of service on or after September 18, 2006 the changes for CPT code 3047F (Hemoglobin A1C Level <-9.0%) now has a coverage code of 10 (Non Pay Category 2 codes) and is listed below for the specific reference screen:

Reference Screen (RF113 Procedure Code Indicators & Value)

	Current
Medicare Coverage	N
Confidential Services	N
Family Planning	N
Sterilization	N
Abortion	N
EPSDT	N
Minimum Age	000
Maximum Age	999

Please note for Coverage Code 10 (Non Pay Category 2 codes) a fee schedule will not be attached to the procedure and it will value at $0.00.

- Effective with dates of service on or after December 1, 2006 the following CPT code 90649 (Human papilloma virus (HPV) vaccine, types 6, 11,16, 18)) has changes for the specific reference screens:

RF113 (Procedure Code Indicators & Values) & RF127 (Procedure OPFS Indicators & Values)

	Current
Medicare Coverage	Y
Confidential Services	N
Family Planning	N
Sterilization	N
Abortion	N
EPSDT	N
Sex	F
Procedure Daily Maximum	1
Minimum Age	009
Maximum Age	020
Laboratory Limit	3
Frequency	1 per lifetime

RF115 (Place of Service)

- 05 Indian Health Service Free-Standing
- 06 Indian Health Service Provider-Base
- 07 Tribal 638 Free-Standing Facility
- 08 Tribal 638 Provider-Based Facility
- 11 Office
- 22 Outpatient Hospital
- 50 Federally Qualified Health Center
- 71 State Or Local Public Health Clinic
- 72 Rural Health Clinic

RF 121 (Valid OPFS Procedure Modifiers) & RF 122 (Valid Procedure Modifiers)
SL State supplied vaccine

RF124 (Procedure Prior Authorization)
Coverage Code 4 (Not covered service/Code not available)
RF773 (Revenue Codes to Procedure Codes)
0250 (Pharmacy)

RF110 (Procedure Codes & Descriptions)
Classification - 9B Immunization Administration & Vaccines/Toxoids

RF769 (Medical Categories of Service)
Category of Service - 01

RF729 (VFC Procedure Codes)
Added to RF729 (vaccine table)

RF618 (Provider Type Rate Schedule)
Provider Types: 05 (Clinic), 08 (MD-Physician), 31(DO-Physician Osteopath), 18 (Physicians Assistant), 19 (Registered Nurse Practitioner)

RF606 (Excluded Services)
Exclude from Emergency Services

Code Updates

- Effective with dates of service on or after July 1, 2005 the code S0088 (Imatinib injection, 100 MG) coverage code was changed from 03 (Covered service/Use other code) to 04 (Not covered service/code not available).

- Effective with dates of service on or after January 1, 2007 the code 0176T (Transluminal dilation of aqueous outflow canal) was assigned a coverage code of 04 (Not covered service/code not available).

- Effective with dates of service after January 1, 2007 the following CPT codes have had a coverage code change from 04 (Not covered service/code not available) to 01 (Covered service/code available)

    * 11975 (Insertion, implantable contraceptive capsules)
    * 11977 (Removal with reinsertion, implantable contraceptive caps)

- Effective with dates of service on or after July 1, 2005 the HCPCS code S0088 (Imatinib injection, 100 mg) now has a coverage code of 04 (Not covered service/code not available) from 03 (Covered service/use other code).

- Effective with dates of service on or after January 1, 2006 the HCPCS code G0333 (Pharmacy dispensing fee for inhalation drugs; initial 30-day supply) as a beneficiary now has a coverage code of 09 (Medicare only) from 01 (Covered service/code available).

- Effective for dates of service January 1, 2007 the following codes can report the modifier QW (CLIA waived test):
    - 83655 (Lead)
    - 87808 (Infectious agent antigen dection by immunoassay)

- Effective for dates of service January 1, 2007 the following codes have an AHCCCS Coverage Code of 09 (Medicare Only):

Code	Description
G0380	Level 1 hospital emergency visit provided in a type B department
G0381	Level 2 hospital emergency visit provided in a type B department
G0382	Level 3 hospital emergency visit provided in a type B department
G0383	Level 4 hospital emergency visit provided in a type B department
G0384	Level 5 hospital emergency visit

Revenue Code Lines

Currently, AHCCCS PMMIS system cannot accept institutional (UB) encounters that exceed 99 revenue code lines. AHCCCS is continuing to review its options for the acceptance of UB encounters that exceed 99 lines. Until a permanent solution is implemented, plans must split or roll-up UB claims/encounters that exceed 99 lines using either current processes in place or the recommendations included below. If after following these recommendations the encounter still exceeds 99 lines, please contact your encounter technical assistant for further direction. Your comments, questions and suggestions are appreciated.

Form Type	Criteria	Suggested Split Rules
Inpatient	Outlier	1. Combine like services on consecutive dates of service.
	Non - Outlier	1. Split service and costs by date of service. 2. Indicate w/ GO Condition Code that split claims are not duplicate. 3. Indicate w/ comments reference to claim split, and retain HP CRN on both records.
		AND/OR
		1. Combine like services on consecutive dates of service.
Outpatient	OPFS	1. Split lab and radiology services (7XXXX and 8XXXX) to a separate claim. 2. Indicate w/ GO Condition Code that split claims are not duplicate. 3. Indicate w/ comments reference to claim split, and retain HP CRN on both records
		OR
		1. Split service and costs by date of service. 2. Indicate w/ GO Condition Code that split claims are not duplicate. 3. Indicate w/ comments reference to claim split, and retain HP CRN on both records.
		AND/OR
		1. Combine like services on consecutive dates of service.
	Other OP	1. Split service and costs by date of service. 2. Indicate w/ GO Condition Code that split claims are not duplicate. 3. Indicate w/ comments reference to claim split, and retain HP CRN on both records.
		AND/OR
		1. Combine like services on consecutive dates of service.

Foresight Implementation Project Communication Update

AHCCCS continues to work with Foresight Corporation (www.foresightcorp.com) to implement their software solution for validation of inbound and outbound electronic data interchange (EDI) transactions. The following is an update of the project:

- One piece of this solution is the Foresight Community Manager, which provides a web-based self-service testing area for the health plans to use to test their transactions in real time. This product has been available for use by four health plans which volunteered to participate in early testing of files against AHCCCS guidelines. We anticipate that Community Manager will be made available to the rest of the plans within the next few weeks.

- The other part of the validation solution which will be visible to all AHCCCS trading partners is a product called Transaction Insight (TI). This will give the health plans a web portal to access information about their transactions: number, success rates, errors, etc. Additionally, there will be some facility to correct certain errors online, revalidate and resubmit selected transactions.

- Demonstrations of TI and training for trading partners will be scheduled over the next several weeks as the project progresses.

Correction

•Effective with dates of service on or **after** July 1, 2007 the following edits will be turned from (S) soft to (H) hard.

- •G150 Procedure requires tooth number
- •G160 Procedure requires surface
- •G170 Procedure requires oral cavity

Age Removed

Effective immediately the ICD-9 code 624.4 (Old laceration or scarring of vulva) the minimum age has been removed.

Age Limit(s)

Effective with dates of service on or after January 1, 2007 the maximum age on CPT code 69930 (Cochlear device implantation, with or without mastoide) has been changed from 20 to 999.

Excluded Services

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Effective with dates of service on or after October 1, 2006 the ICD-9 Diagnosis Code 331.83 (Mild cognitive impairment, so stated) has been added to the reference screen RF606 (Excluded services).

Modifier(s)

- Effective with dates of service on or after September 1, 2006 the modifier QN (Ambulance service furnished directly by a provider of services) can be reported on HCPCS code A0382 (BLS routine disposable supplies).

- Effective with dates of service on or after November 7, 2006 the following codes can no longer be reported with the SL (State supplied vaccine) modifier:

    - 90718 (Tetanus And Diphtheria Toxoids (TD) Adsorbed When Administered)
    - 90721 (Diphtheria, Tetanus Toxoids, And Acellular Pertussis vaccine)
    - 90740 (Hepatitis B Vaccine, Dialysis Or Immunosuppressed Patient dosage)

- Effective with dates of service on or after January 1, 2007 the modifier QW (CLIA Waived) can be reported on the following codes:

    - 83655 (Lead)
    - 87808 (Infectious agent antigen detection by immunoassay)

- Effective with dates of service on or after November 1, 2006 the code A4640 (Replacement pad for use with medically necessary alternating) can be reported with the modifier NU (New equipment).

- Effective with dates of service on or after September 1, 2006 the modifier 53 (Discontinued procedure) can be reported on CPT code 53852 (Transurethral destruction of prostate tissues; by radiofrequency thermotherapy).

Place of Service (POS) Added

The following codes had additional POS added.

Procedure Code	Description	Place of Service	Description	Effective Date
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	99	Other unlisted facility	7/1/2005
S9434	Modified solid food supplements for inborn errors of metabolism	12	Home	4/1/2003
		99	Other unlisted facility	4/1/2003
1039F	Intermitten asthma	5	Indian Health Service fee-standing	7/1/2006
		6	Indian Health Service provider-base	7/1/2006
		7	Tribal 638 free-standing facility	7/1/2006
		8	Tribal 638 provider-based facility	7/1/2006
		11	Office	7/1/2006
		12	Home	7/1/2006
		15	Mobile unit	7/1/2006
		21	Inpatient hospital	7/1/2006
		22	Outpatient hospital	7/1/2006
		23	Emergency room - hospital	7/1/2006
		31	Skilled nursing facility	7/1/2006
		32	Nursing facility	7/1/2006
		33	Custodial care facility	7/1/2006
		50	Federally qualified health center	7/1/2006
		72	Rural health clinic	7/1/2006
93925	Duplex scan of lower extremity arteries or arterial bypass	31	Skilled Nursing Facility	9/1/2006
93922	Noninvasive physiologic studies or upper or lower extremeties	31	Skilled Nursing Facility	9/1/2006
C9230	Injection, Abatacept, per 10 mg	5	Indian Health Service fee-standing	7/1/2006
		6	Indian Health Service provider-base	7/1/2006
		7	Tribal 638 free-standing facility	7/1/2006
		8	Tribal 638 provider-based facility	7/1/2006
		11	Office	7/1/2006
		50	Federally qualified health center	7/1/2006
		71	State or local public health clinic	
		72	Rural health clinic	7/1/2006

Place of Service (POS)

•Effective with dates of service on or after January 1, 2006 the CPT code 76376 (3D Rendering with interpretation and computer reading) can now be reported with POS 11 (Office).

•Effective with dates of service on or after July 1, 2006 the HCPCS code K0736 (Skin protection/positioning wheelchair seat cushion) can now be reported with POS 12 (Home).